

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35405

State File No.

FILED NOV 10 1948

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County VERNON
(b) City or town MILB
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 6 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME JOHN WILLIAM HERY FORD

3. (b) If veteran, name war. - 3. (c) Social Security No. -

4. Sex MALE 5. Color or race W. 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife SALLIE JANE 6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased MAY 9 1865 (Month) (Day) (Year)

8. AGE: Years 83 Months 5 Days 16 If less than one day hr. min.

9. Birthplace FORT SCOTT KANSAS (City, town, or county) (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business

12. Name WILLIAM HERY FORD
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)
14. Maiden name MILLIE EALS
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant SALLIE HERY FORD
(b) Address MILB, MO.

17. (a) BURIAL (b) Date thereof OCT. 27 48 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation JOHNSON CEMETARY

18. (c) Signature of funeral director Sheldon

(b) Address Nov 6, 1948 (c) Signature of Registrar Mrs. Ruth Faith (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County VERNON
(c) City or town MILB (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 25 year 1948 hour 11:05 minute A. M.

21. I hereby certify that I attended the deceased from OCT 19 48 to OCT 25 48 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 6 days

Due to Hypertensive Heart Disease Due to Don't know

Other conditions Advanced age (Include pregnancy within 3 months of death)

Major findings: Of operations none Of autopsy none Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence -
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? -

While at work? (Specify type of place) (e) Means of injury no
23. Signature W. B. Povey (Name or other)
Address Nevada Mo Date signed Nov 24 48

RECEIVED

District Health Officer No. 7

District File Number 10-481305

Date Filed 11-9-48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,
working under my personal supervision.

Signed L. Gerald Beeny

Licensed Embalmer No. 4203

P. O. Address. Sheldon, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.